Addendum to the DC Guidance and Standards for HIV Prevention Interventions

September 2003

Table of Contents

Introduction

The purpose of this Addendum is to provide additional guidance and standards on the implementation of primary HIV prevention interventions in the District of Columbia, based on new requirements and definitions issued by the Centers for Disease Control and Prevention (CDC) in 2003.

The information is taken principally from three CDC publications:

- Advancing HIV Prevention: Interim Technical Guidance for Selected Interventions
- Draft CDC Technical Assistance Guidelines for Health Department HIV Prevention Program Performance Indicators
- Glossary of HIV prevention terms **(***definitions specific to how the terms are used in CDC Program Announcement 04012 and the HIV Prevention Community Planning Guidance)*

Follow the Guidance and Standards in Volume 2

Organizations that are funded by the HIV/AIDS Administration (HAA) to implement HIV prevention interventions in the District must follow the guidelines in the **Guidance and Standards for HIV Prevention Interventions**, which is **Volume 2** of the District of Columbia HIV Prevention Plan for 2003-2004, and in this **Addendum**.

These documents describe the **standards** that should be applied consistently in the delivery of HIV prevention interventions. They must be followed in all cases.

The documents also provide overall **guidance** in developing and implementing HIV prevention interventions. The overall **guidance** is intended to be more flexible. HAA recognizes that, depending on the client population, setting, and other factors, the guidance can and should be tailored to fit individual program needs.

HAA will evaluate the design of HIV prevention programs and interventions before they are implemented to ensure that they follow the guidance and standards for interventions.

Requirements for all HIV Prevention Interventions

Sub-grantees must provide services that:

- Focus on those most at risk of transmitting or acquiring HIV infection, reflecting the priorities established in the Comprehensive HIV Prevention Plan;
- Are based on scientific theory, or have evidence of demonstrated or probable outcome effectiveness (see the CDC's most current Compendium of HIV Prevention Interventions with Evidence of Effectiveness and glossary);
- Are directed by written procedures or protocols;
- Are acceptable to and understood by the target population, i.e., are culturally and linguistically appropriate; and
- Have quality assurance and evaluation procedures in place.

Definitions

Evidenced-based: Behavioral, social, and structural interventions that are relevant to HIV risk reduction, have been tested using a methodologically rigorous design, and have been shown to be effective in a research setting.

These evidence- or science-based interventions have been evaluated using behavioral or health outcomes; have been compared to a control/comparison group(s) (or pre-post data without a comparison group if a policy study); had no apparent bias when assigning persons to intervention or control groups or were adjusted for any apparent assignment bias; and, produced significantly greater positive results when compared to the control/comparison group(s), while not producing negative results.

CDC expects its grantees to deliver interventions based on a range of evidence. These interventions may include:

- *Evidenced-based interventions* (that meet the criteria described above and can be found in CDC's *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* (1999). These interventions can either be implemented exactly as intended and within a context similar to the original intervention or adapted and tailored to a different target population if the core elements of the intervention are maintained.
- *Interventions with insufficient evidence of effectiveness based on prior outcome monitoring data suggesting positive effects, but that cannot be rigorously proven*. These interventions must be based on sound science and theory; a logic model that matches the science and theory to the intended outcomes of interest; and a logic model that matches relevant behavioral-epi data from their community and target population.

Resources

- The link below will take you to a document with summary descriptions of science-based interventions proven to reduce risk behaviors associated with the acquisition or transmission of HIV. All of the interventions the CDC's criteria of effectiveness. The interventions have been effective with a variety of populations and have been delivered in individual, group, and community-level settings. They were created to assist in the selection appropriate intervention for different populations.

  http://www3.utsouthwestern.edu/preventiontoolbox/interven/Final%20IFS%20Document.pdf

- A copy of the most recent version of the CDC's *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* can be found in Volume 2 of the District of Columbia HIV Prevention Plan for 2003-2004. It can also be downloaded from this Internet site:

  http://www.cdc.gov/hiv/pubs/hivcompendium/hivcompendium.htm

  The Compendium includes descriptions of different interventions and information on how to obtain additional information on each intervention.

- *Replicating Effective Programs Plus*. Information on "boxed" interventions that can be ordered from the organizations that developed them. Training is also available on how to implement the interventions.
  http://www.cdc.gov/hiv/projects/rep/default.htm

- Model programs for different populations:
  http://www.caps.ucsf.edu/projectindex.html

- Curricula for a series of workshops for HIV+ individuals:
  http://ari.ucsf.edu/pdf/USCA9.pdf

- *Designing Primary Prevention for People Living with HIV*:
  http://ari.ucsf.edu/pdf/primaryprevention.pdf

- *Prevention with Positives: A Guide to Effective Programs* and several other publications related to HIV risk reduction interventions for HIV-positive individuals: http://www.hivinfo.org/docs/pdf/training/PwP%20Guide.pdf

- *Prevention with Positives Resources*, including curricula:
  http://www.hivinfo.org/cac/providerinfo/positiveprevention.shtml

  and http://ari.ucsf.edu/policy/pwp.htm

- *Principles of HIV Prevention in Drug-Using Populations*, from the National Institute of Drug Abuse: http://drugabuse.gov/POHP/

- *HIV Prevention Among Injecting Drug Users,* from the CDC:
  http://www.cdc.gov/idu/

- The UT-Southwestern ACCESS guide "toolbox" provides innumerable resources for HIV prevention programs, including curricula, and has a Spanish language section:

  http://www3.utsouthwestern.edu/preventiontoolbox/

- The University of Kansas' Community Tool Kit provides over 6,000 pages of practical skill-building information on over 250 different topics. Topic sections include step-by-step instruction, examples, check-lists, and related resources:

  http://ctb.ku.edu/

- A compendium of links related to constructing logic models (not HIV specific) from CDC's Evaluation Working Group:

  http://www.cdc.gov/eval/resources.htm

CDC's Program Performance Indicators

What Are Program Performance Indicators?

HAA is required to report on a core set of indicators that are appropriate program activities. A program performance indicator (or measure) is a piece of information, fact, or statistic that provides insight into the performance of a program. It helps the CDC understand progress toward specified outcomes, the District of Columbia's capacity to carry out its HIV prevention work, the activities it performs in carrying out its work, and the HIV prevention outcomes it is trying to achieve.

Much of the information that HAA must report to the CDC, regarding the progress in achieving the program indicators, comes from the reports that sub-grantees must provide HAA on the implementation of interventions funded by HAA.

Why Are Program Performance Indicators Important?

They Reflect Good Management. A successful strategic and operational planning process builds in accountability for results. Performance indicators are the tools used to measure performance and evaluate progress on these plans.

Measuring Performance Emphasizes Results. Measuring performance means setting performance expectations (targets), comparing actual performance with these targets, and using these data to continuously improve processes.

What Gets Measured Gets Done. People working in HIV prevention do so because of their commitment to helping people stay healthy. Performance measurement helps organizations focus on what is important in achieving that goal. By comparing actual with expected results, it enables all stakeholders to evaluate progress towards goals and objectives.

The program performance indicators adopted by the CDC's Division of HIV/AIDS Prevention and outlined in Program Announcement – 04012 comprise a plan that describes the Division's intended performance measures in a number of distinct domains that reflect critical areas of HIV prevention planning, services, and evaluation.

Program Performance Indicator	**Area of Interest**
Health Education/Risk Reduction	
H.1: Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI), group level interventions (GLI), and Prevention Case Management (PCM).	Retention
H.2: Proportion of the intended number of the target populations to be reached with any of the following specific interventions – ILI or GLI or PCM – who were actually reached.	Reach of intended target populations

Program Performance Indicator	Area of Interest
H.3: The mean number of outreach contacts required to get one person to access any of the following services: Counseling & Testing, Sexually Transmitted Disease Screening & Testing, ILI, GLI or PCM. [1]	Impact of outreach and utilization of services
Prevention for HIV Infected Persons	
I.1: Proportion of HIV infected persons that completed the intended number of sessions for Prevention Case Management.	Retention among infected persons
I.2: Percent of HIV infected persons who, after a specified period of participation in Prevention Case Management, report a reduction in sexual or drug using risk behaviors or maintain protective behaviors with seronegative partners or with partners of unknown status. [2]	Impact of PCM among infected persons

[1] The proportion of all individuals referred to HIV counseling & testing, sexually transmitted disease screening, ILI, GLI or PCM that received one of those services.

[2] Behavior change is to be measured at 30 days from enrollment in PCM or 2 weeks following the 3rd session of PCM, whichever comes first.

Criteria for HIV Prevention Interventions

Individual-Level Interventions (ILI)

Target Population:

Persons enrolled in ILI for HIV prevention, regardless of their HIV status.

Minimum number of sessions to be completed:

One session. (ILI can be a one-time intervention, or the client and counselor can meet multiple times.)

Content to be covered (i.e., a set of topic areas or learning objectives that must be covered for the intervention to be considered complete.)**:**

ILI is client-centered counseling. It should include a discussion of risk behaviors identified by the client; acknowledge substance use, housing needs and other needs as possible barriers to HIV prevention; and it should provide linkages to services for HIV testing, STD screening, mental health services, housing and substance use treatment.

Process monitoring data:

Number of persons that completed the pre-determined number of sessions for this intervention.

Group-Level Interventions (GLI) or Psycho-Educational Skills-Building Workshops

Target Population:

Persons enrolled in GLI for HIV prevention, regardless of their HIV status.

Minimum number of sessions to be completed:

Three sessions, for a minimum total of 9 hours

GLI does *not* include "one-shot" educational presentations or lectures that lack a skills component. Those types of activities are considered Health Communication/Public Information interventions.

Content to be covered:

- Information and education on risk and harm reduction; self-risk; self-esteem; self-efficacy; communication and negotiation skills; problem and conflict resolution; substance abuse; peer pressure; cultural norms such as religious beliefs and family values; and gender identity and sexual orientation.
- Co-factors that are not necessarily related to HIV but may prevent members of the target population from engaging in safer sex and other healthy behavior consistently, such as a history of sexual, physical and mental abuse; poverty, homelessness, unemployment, lack of social support, mental health stressors and lack of access to prevention resources due to lack of knowledge of services, language or literacy.

Process monitoring data:

Number of persons that completed the pre-determined number of sessions for this intervention.

Prevention Case Management (PCM)

Target Population:

Persons enrolled in PCM for HIV prevention, regardless of their HIV status.

Minimum number of sessions to be completed:

There is no minimum or maximum number of sessions for this intervention. The number of sessions is pre-determined upon intake for each client based on a standardized, client-centered risk assessment to ascertain the content to be covered and the time required to adequately cover the content.

Content to be covered:

PCM is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage. Additional information on the content and implementation of PCM can be found in the CDC's Prevention Case Management Guidance, in Volume 2 of the HIV Prevention Plan for 2003-2004.

Process monitoring data:

Number of persons that completed the pre-determined number of PCM sessions, regardless of their HIV status

Outcome monitoring data:

Number of HIV-positive persons in PCM reporting a reduction in sexual or drug using risk behaviors or maintain protective behaviors with seronegative partners or with partners of unknown status. Behavior change is to be measured at 30 days from enrollment or 2 weeks following the 3rd session of PCM, whichever comes first.

Sexual or drug using risk behaviors

- Unprotected anal intercourse
- Unprotected vaginal intercourse
- Sharing of needles syringes or injection equipment

Protective behaviors

- Abstinence
- Consistent condom use (always, or no unprotected sex acts)
- Use sterile syringe every injection event or no sharing of injection equipment

- No injection drug use

Outreach

Target Population:

Individuals reached through active outreach on the street, in parks, in homeless shelters, in drop-in centers or elsewhere, regardless of their HIV status.

Minimum number of sessions to be completed:

One face-to-face contact lasting at least 5 minutes that includes an assessment of the person's HIV prevention needs.

Content to be covered:

Outreach involves providing risk reduction or skills building HIV prevention services by approaching people who may be in need. The essential element of all outreach activity is the outreach worker having contact with a prospective client and making a referral, when appropriate, for any of the following services: HIV counseling and testing, STD screening, ILI, GLI or PCM. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits and educational materials

Process monitoring data:

Number of persons reached through face-to-face contacts lasting at least 5 minutes that include an assessment of the person's HIV prevention needs.

Referral

Target Population:

Individuals reached through active outreach or through ILI, GLI or PCM and provided with a referral, regardless of their HIV status

Minimum number of sessions to be completed:

One face-to-face contact lasting at least 5 minutes that includes an assessment of the person's needs.

Content to be covered:

A referral is a client-centered activity through which individuals are provided with information to obtain a specific (time, place, date) service, such as for HIV testing, STD screening, mental health services, housing, substance use treatment or other HIV prevention interventions (ILI, GLI or PCM).

Types of referrals:

Active referral – direct linkage (access) to a service provider or agency, (i.e., transporting the client to the agency).

Passive referral – information about a prevention activity or service provider is given to a prospective client during an outreach contact. The prospective client must take the next step to access that service.

Passive referral with agency verification – confirmation by the service provider subsequent to the referral that the prospective client received services.

Passive referral with client verification – confirmation by the client at the time of service that he/she was referred to the service provider or agency.

Process monitoring data:

The number of individuals who (1) were referred to and (2) received one of the following services: HIV counseling & testing, sexually transmitted disease screening and care, ILI, GLI or PCM.

Quality Assurance Requirements

All sub-grantees and sub-contractors must develop, implement, and maintain quality assurance plans in the following programmatic areas:

Health Education/Risk Reduction (HE/RR) Activities

(a) Develop and implement a mechanism to ensure HE/RR activities are appropriate, understandable and acceptable for the specific populations served.

(b) Develop and maintain a mechanism to ensure the consistency, accuracy, and relevance of information provided to the public through local hotlines and other channels, including information about referral services.

(c) Develop or use existing standard procedures or protocols for interventions implemented by health departments and their contractors.

(d) Actively monitor services and programs provided by funded CBOs and other contractors to assist in identifying training and technical assistance needs and to ensure that interventions are implemented as planned and that program objectives are met.

(e) Use feedback from client satisfaction surveys in assessing the services provided, including prevention services for people living with HIV/AIDS. Other science-based methods of assessing services provided can also be used.

Counseling, Testing and Referral (CTR) services and Partner Counseling and Referral (PCR) services

(a) Counseling – Conduct routine, periodic assessments to ensure that the counseling being provided includes the recommended, essential counseling elements (Please reference the *CDC Revised Guidelines for HIV Counseling, Testing, and Referral*. MMWR 2001,50 (RR-19); 1-58). Essential elements may include but are not limited to the following: training and continuing education; supervisor observation with feedback to counselors; case conferences; counselor or client satisfaction evaluations; and periodic evaluation of space, flow, and time concerns.

(b) HIV Testing – Develop and implement a quality assurance system for all CTR and PCRS providers, with special attention to ensuring that HIV-positive clients learn their test results. Develop and implement a quality assurance system for implementation of HIV rapid testing.

(c) Referral – Develop and implement a mechanism for assessing the proportion of HIV-positive persons referred for additional services that complete their referrals. Review data and improve process as necessary.

(d) PCRS – Develop, implement, and maintain a system to assess the PCRS program and improve its function, e.g., improving the percentage of persons who receive PCRS, the quality of PCRS interview sessions, and the notification of partners.

(e)

Policies, Procedures, and Training

(a) Develop comprehensive written quality assurance policies and procedures to ensure that all HIV prevention activities are delivered in an appropriate, competent, and sensitive manner.

(b) Make quality assurance policies and procedures available to all program staff (health department and their contractors).

(c) Deliver training to all staff providing HIV prevention activities, especially those staff providing CTR, PCRS, and HE/RR (health department and their contractors).

(d) Train all managers (health department and their contractors) to ensure that quality assurance policies and procedures are followed.

Data Collection – Develop, implement, and maintain a system to assess the quality of data collection.

Resources

Recommendations on quality assurance can be found in the following documents, which are included in Volume 2 of the District of Columbia HIV Prevention Plan for 2003-2004:

- **Guidance and Standards for Individual Prevention Counseling** (Volume 2, Page 16)
- **General Considerations Regarding HERR Activities** (Volume 2, Page 7) The CDC's "Guidelines for Health Education and Risk Reduction (HERR) Activities" contains additional information on quality assurance, including several appendices with sample quality assurance forms. The document can be downloaded from this CDC internet site:

  http://www.cdc.gov/hiv/HERRG/HIV_HERRG.htm
- **Prevention Case Management - Guidance** (Volume 2, Page 33)
- **Partner Counseling and Referral Services (PCRS)** (Volume 2, Page 63)
- **Health Communications / Public Information (HC/PI)** (Volume 2, Page 83)
- **Revised CDC Guidelines for HIV Counseling, Testing, and Referral and Revised Recommendations for HIV Screening of Pregnant Women** (Volume 2, Page 107)
- **Rapid Testing**: Recommendations on quality assurance for rapid testing can be found in two documents that can be downloaded from this CDC web site:

  http://www.cdc.gov/hiv/rapid_testing/materials/QA-Guide.htm

  Quality Assurance Guidelines for Testing Using the OraQuick® Rapid HIV-1 Antibody Test and Appendices: Government Regulations and Sample Forms (PDF only - 407 KB, 9 pages)

GUIDELINES FOR HIV REFERRALS

District of Columbia Department of Health
HIV/AIDS Administration

Adapted from the Centers for Disease Control and Prevention's Revised Guidelines for HIV Counseling, Testing, and Referral and Revised Recommendations for HIV Screening of Pregnant Women. MMWR November 9, 2001 / Vol. 50 / No. RR-19

Definition of Referral

In the context of HIV prevention counseling and testing, referral is the process by which immediate client needs for care and supportive services are assessed and prioritized and clients are provided with assistance (e.g., setting up appointments, providing transportation) in accessing services. Referral should also include follow-up efforts necessary to facilitate initial contact with care and support service providers.

In this context, referral does not include ongoing support or management of the referral or case management. Case management is generally characterized by an ongoing relationship with a client that includes comprehensive assessment of medical and psychosocial support needs, development of a formal plan to address needs, substantial assistance in accessing referral services, and monitoring of service delivery.

Typical Referral Needs

Clients should be referred to services that are responsive to their priority needs and appropriate to their culture, language, sex, sexual orientation, age, and developmental level. Examples of these services include

Prevention case management. Clients with multiple and complex needs that affect their ability to adopt and sustain behaviors to reduce their risk for transmitting or acquiring HIV should receive or be referred for prevention case management services, including ongoing prevention counseling. Prevention case management can help coordinate diverse referral and follow-up concerns.

Medical evaluation, care, and treatment. HIV-positive clients should receive or be referred to medical services that address their HIV infection (including evaluation of immune system function and screening, treatment, and prevention of opportunistic infections). Screening and prophylaxis for opportunistic infections and related HIV-conditions (e.g., cervical cancer) are important for HIV-positive persons. In addition, coinfection with HIV and communicable diseases (e.g., TB, STDs, and hepatitis) can, if untreated, pose a risk to susceptible community members. Thus, providers of HIV testing should be familiar with appropriate screening tests (e.g., TB), vaccines (e.g., hepatitis A and B), STD and prophylactic TB treatment, and clinical evaluation for active TB disease to ensure that these communicable diseases are identified early and appropriate clinical referrals are made, even if clients forego outpatient HIV treatment.

Partner counseling and referral services. Persons with HIV-positive test results should receive or be referred to services to help them notify their sex or injection drug

equipment–sharing partners or spouses regarding their exposure to HIV and how to access CTR. Guidelines for PCRS are available.

Reproductive health services. Female clients who are pregnant or of childbearing age should receive or be referred to reproductive health services. HIV-positive pregnant women should be referred to providers who can provide prevention counseling and education, initiate medical therapy to prevent perinatal transmission, and provide appropriate care based on established treatment guidelines (see Revised Recommendations for HIV Screening of Pregnant Women in Volume 2 of the HIV Prevention Plan for 2003-2004).

Drug or alcohol prevention and treatment. Clients who abuse drugs or alcohol should receive or be referred to substance or alcohol abuse prevention and treatment services.

Mental health services. Clients who have mental illness, developmental disability, or difficulty coping with HIV diagnosis or HIV-related conditions should receive or be referred to appropriate mental health services.

Legal services. Clients who test positive should be referred to legal services as soon as possible after learning their test result for counseling on how to prevent discrimination in employment, housing, and public accommodation by only disclosing their status to those who have a legal need to know.

STD screening and care. Clients who are HIV-positive or at increased risk for HIV are at risk for other STDs and should receive or be referred for STD screening and treatment.

Screening and treatment for viral hepatitis. Many clients who are HIV-positive or at increased risk for HIV are at increased risk for acquiring viral hepatitis (A, B, and C). Men who have sex with men and IDUs should be vaccinated for hepatitis A. All clients without a history of hepatitis B infection or vaccination should be tested for hepatitis B, and if not infected, should receive or be referred for hepatitis B vaccination. In addition, clients who inject drugs should be routinely recommended testing for hepatitis C. All clients who are infected with hepatitis viruses should be referred for appropriate treatment.

Other services. Clients might have multiple needs that can be addressed through other HIV prevention and support services (e.g., assistance with housing, food, employment, transportation, child care, domestic violence, and legal services). Addressing these needs can help clients access and accept medical services and adopt and maintain behaviors to reduce risk for HIV transmission and acquisition. Clients should receive referrals as appropriate for identified needs.

Implement and Manage Referral Services

Clients should receive help accessing and completing referrals, and completion of referrals should be verified. The following elements should be considered essential to the development and delivery of referral services.

Assess Client Referral Needs

Providers should consult with the client to identify essential factors that a) are likely to influence the client's ability to adopt or sustain behaviors to reduce risk for HIV transmission or acquisition or b) promote health and prevent disease progression. Assessment should include examination of the client's willingness and ability to accept and complete a referral. Service referrals that match the client's self-identified priority needs are more likely to be successfully completed than those that do not. Priority should be placed on ensuring that HIV-positive clients are assessed for referral needs related to medical care, PCRS, and prevention and support services aimed at reducing the risk for further transmission of HIV. When a provider cannot make appropriate referrals or when client needs are complex, clients should be referred to a case management system.

Plan the Referral

Referral services should be responsive to clients' needs and priorities and appropriate to their culture, language, sex, sexual orientation, age, and developmental level. In consultation with clients, providers should assess and address any factors that make completing the referral difficult (e.g., lack of transportation or child care, work schedule, cost). Research has indicated that referrals are more likely to be completed if services are easily accessible to clients.

Help Clients Access Referral Services

Clients should receive information necessary to successfully access the referral service (e.g., contact name, eligibility requirements, location, hours of operation, telephone number). Research has indicated that providing assistance (e.g., setting an appointment, addressing transportation needs) for some clients promotes completion of referrals. Clients must give consent before identifying information to help complete the referral can be shared. Outreach workers and peer counselors/educators can be an important and effective resource to help clients identify needs and plan successful referrals. Referrals are more likely to be completed after multiple contacts with outreach workers.

Document Referral and Follow-Up

Providers should assess and document whether the client accessed the referral services. If the client did not, the provider should determine why; if the client did, the provider should determine the client's degree of satisfaction. If the services were unsatisfactory, the provider should offer additional or different referrals. Documentation of referrals made, the status of those referrals, and client satisfaction with referrals should help providers better meet the needs of clients. Information obtained through follow-up of referrals can identify barriers to completing the referral; responsiveness of referral services in addressing client needs, and gaps in the referral system.

Ensure High-Quality Referral Services

Providers of referral services should know and understand the service needs of their clients, be aware of available community resources, and be able to provide services in a manner appropriate to the clients' culture, language, sex, sexual orientation, age, and developmental level, given local service system limitations.

Education and Support of Staff Members

Staff members providing referral services must understand client needs, have skills and resources to address these needs, have authority to help the client procure services, and be able to advocate for clients.

Training and Education. Providers should ensure that staff members receive adequate training and continuing education to implement and manage referrals. Training and education should address resources available and methods for managing referrals, as well as promote understanding of factors likely to influence the client's ability and willingness to use a referral service (e.g., readiness to accept the service, competing priorities, financial resources). Referrals are more likely to be completed when a provider is able to correctly evaluate a client's readiness to adopt risk-reducing behaviors. Research has indicated that cross training increases knowledge and understanding of community resources among providers and can indicate gaps in services.

Authority. Staff members providing referrals must have the authority necessary to accomplish a referral. Supervisors must ensure that staff members understand referral policy and protocol and have the necessary support to provide referrals. This requires the authority of one provider to refer to another (e.g., through memoranda of agreement) or to obtain client consent for release of medical or other personal information.

Advocacy. Staff members who negotiate referrals must possess knowledge and skills to advocate for clients. Such advocacy can help clients obtain services by mediating barriers to access to services and promoting an environment in which providers are better informed regarding the needs and priorities of their clients.

Provider Coordination and Collaboration

Providers should develop and maintain strong working relationships with other providers and agencies that might be able to provide needed services. Providers who offer HIV prevention counseling and testing but not a full range of medical and psychosocial support services should develop direct, clearly delineated arrangements with other providers who can offer needed services. Coordination and collaboration promotes a shared understanding of the specific medical and psychosocial needs of clients requiring services, current resources available to address these needs, and gaps in resources.

Memoranda of agreement or other forms of formal agreement are useful in outlining provider/agency relationships and delineating roles and responsibilities of collaborating providers in managing referrals. When confidential client information is shared between coordinating providers, such formal agreements are essential. These agreements should be reviewed periodically and modified as appropriate.

Referral Resources

Knowledge of available support services is essential for successful referrals. When referral resources are not available locally, providers should identify appropriate resources and link clients with them. A resource guide should be developed and maintained to help staff members make appropriate referrals (Box 7). Information regarding community resources can be obtained from local health planning councils, consortia, and community planning groups. Local, state, and national HIV/AIDS information hotlines or websites (e.g., NPIN), community-based health and human service providers, and state and local public health departments can also provide information.

Contents of a referral resource guide

For each resource, the referral resource guide should specify the following:

- Name of the provider or agency
- Range of services provided
- Target population
- Service area(s)
- Contact names and telephone and fax numbers, street addresses, e-mail addresses
- Hours of operation
- Location
- Competence in providing services appropriate to the client's culture, language, sex, sexual orientation, age, and developmental level
- Cost for services and acceptable methods of payment
- Eligibility
- Application materials
- Admission policies and procedures
- Directions, transportation information, and accessibility to public transportation
- Client satisfaction with services

Guidelines and Procedures for the Review of HIV Prevention Educational Materials

District of Columbia
HIV Prevention Community Planning Group

Rationale

The Centers for Disease Control and Prevention (CDC) requires that "all written materials, pictorials, questionnaires, survey instruments, proposed group educational sessions, educational curricula and the like material" funded directly by the CDC or indirectly through the Department of Health, be reviewed and approved for use by a review panel representing the community. The intent of the review is to determine if the materials are in compliance with Section 2500 of the Public Health Service Act. (See Attachment 1)

This requirement "applies regardless of whether the applicant plans to conduct the total program activities or plans to have part of them conducted through other organization(s) and whether program activities involve creating unique materials or using/distributing modified or intact materials already developed by others."

The process is governed by the basic principles of materials review contained in the CDC document "Interim Revision of Requirements for Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control Assistance Programs, June 15, 1992." (See Attachment 1)

Review and Approval

The Materials Review Committee (MRC) of the HIV Prevention Community Planning Group (HPCPG) is in charge of reviewing materials for the District of Columbia Department of Health. The Committee is composed of HPCPG members, community representatives, and a representative of the HIV/AIDS Administration (HAA). Staff of HAA's Prevention and Interventions Division acts liaison between the Committee and the community-based organizations and other groups that submit materials for approval by the Committee.

Criteria

The MRC considers six criteria listed in the CDC Requirements:

1. The material uses terms, descriptors or displays necessary for the intended audience to understand dangerous behaviors and explains less risky practices concerning HIV transmission. (Information on the intended audience/s is provided in the forms that must accompany all materials submitted for review.)
2. The material does not promote or encourage, directly, homosexual or heterosexual sexual activity or intravenous substance abuse.

3. The program provides accurate information about various means to reduce an individual's risk of exposure to, or the transmission of, HIV.
4. The material is not obscene.
5. The program includes information about the harmful effects of promiscuous sexual activity and intravenous substance abuse, and the benefits of abstaining from such activities.
6. Educational sessions do not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices.

Timeline

Organizations that need the review and approval of the Committee must submit the materials for review with sufficient time to allow the Materials Review Committee to conduct its review. At a minimum, materials should be submitted no later than three (3) weeks before the organization plans to use the materials.

Procedures for Submission of Materials

Organizations funded directly by the CDC or by the Department of Health are responsible for submitting their materials for review before they are used in any way. According to the CDC guidelines, the Materials Review Committee must "review and approve all applicable materials prior to their distribution and use in any activities funded in any part with CDC assistance funds."

In the case of materials that are under development, organizations may submit draft text, drawings, scripts, or detailed descriptions for written materials, pictorials or audiovisuals.

Organizations are not requited to submit the following to the Materials Review Committee:

- Materials developed by the CDC or distributed through NPIN, the CDC's National Prevention Information Network;
- Materials developed and distributed by national organizations like the Red Cross; and
- Materials developed and sold by Channing Bette and ETR Associates.

Submission of Materials by HAA Sub-grantees

Sub-Grantees must submit 10 copies of the material to the Project Officer (program monitor) for their grant, using the Materials Submission Form (Attachment 2). This document requests information on the name and nature of the material, and the intended audience for the material. No materials will be reviewed unless the Submission Form accompanies them.

Organizations funded by HAA should mail or hand-deliver the materials to:

(Name of Project Officer/Program Monitor)

Materials Review Committee
HIV/AIDS Administration
717 14th Street NW, Suite 1000
Washington DC 20005

The program monitor will review the materials to determine if they meet the needs of the program's target population as reflected in the program plan and the goals and objectives of the program. If the materials meet these criteria, the Project Officer submits the materials to the Review Committee (Attachment 3). If the material does not meet these criteria, the Project officer will notify the sub-grantee and make recommendations on changes to the material.

Submission of Materials by Organizations Directly Funded by CDC

Organizations that are directly funded by the CDC should submit 10 copies of the materials for those programs to the MRC liaison. The materials should be mailed or hand-delivered to:

Ronnie Vanderhorst
Materials Review Committee
HIV/AIDS Administration
717 14th Street NW, Suite 1000
Washington DC 20005

Reviews by the MRC and the Program Monitor

Once materials are reviewed by the MRC, the Chair of the committee will sign a form that notes the votes of the committee in favor or against approval of the materials (Attachment 4).

The HAA liaison then provides a copy of the material, along with the approval/disapproval form from the MRC, to the program monitor. The program monitor then conducts her/his own review, to determine if the material is in compliance with Section 2500 of the Public Health Service Act. The program monitor fills out a separate approval/disapproval form, and both forms – from the MRC and from the monitor – are then sent to the submitting organization and to the CDC.

Sub-grantees should file the approval form along with a copy of the material. CDC or HAA may request at any time to see the approval forms for all materials used for CDC- or HAA-funded HIV prevention programs.

If the MRC does not approve of the use of the materials, the decision form will note the reasons for the disapproval. The organization that submitted the materials can revise the materials and submit them for another review.

Department of Health and Human Services
Centers for Disease Control and Prevention

Interim Revision of Requirements for Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control Assistance Programs

June 15, 1992

1. Basic Principles

Controlling the spread of HIV infection and AIDS requires the promotion of individual behaviors that eliminate or reduce the risk of acquiring and spreading the virus. Messages must be provided to the public that emphasize the ways by which individuals can fully protect themselves from acquiring the virus. These methods include abstinence from the illegal use of IV drugs and from sexual intercourse except in a mutually monogamous relationship with an uninfected partner. For those individuals who do not or cannot cease risky behavior, methods of reducing their risk of acquiring or spreading the virus must also be communicated. Such messages can be controversial. These principles are intended to provide guidance for the development and use of educational materials, and to require the establishment of Program Review Panels to consider the appropriateness of messages designed to communicate with various groups.

a. Written materials (e.g., pamphlets, brochures, fliers), audiovisual materials (e.g., motion pictures and video tapes), and pictorials (e.g., posters and similar educational materials using photographs, slides, drawings, or paintings) should use terms, descriptors, or displays necessary for the intended audience to understand dangerous behaviors and explain less risky practices concerning HIV transmission.

b. Written materials, audiovisual materials, and pictorials should be reviewed by Program Review Panels consistent with the provisions of section 2500(b), (c), and (d) of the Public Health Service Act, 42 U.S.C. 300ee(b), (c), and (d), as follows:

"Sec. 2500. Use of Funds

(b) Contents of Programs – All programs of education and information receiving funds under this title shall include information about the harmful effects of promiscuous sexual activity and intravenous substance abuse, and the benefits of abstaining from such activities.

(c) Limitation – None of the funds appropriated to carry out this title may be used to provide education or information designed to promote or encourage, directly, homosexual or heterosexual sexual activity or intravenous substance abuse.

(d) Construction – Subsection (c) may not be construed to restrict the ability of an education program that includes the information required in subsection (b) to provide accurate information about various means to reduce an individual's risk of exposure to, or the transmission of, the etiologic agent for acquired immune deficiency syndrome, provided that any informational materials used are not obscene."

c. Educational sessions should not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices.

d. Messages provided to young people in schools and in other settings should be guided by the principles contained in "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" (MMWR 1988;37 [suppl. No. S-2]).

2. Program Review Panel

a. Each recipient will be required to establish or identify a Program Review Panel to review and approve all written materials, pictorials, audiovisuals, questionnaires or survey instruments, and proposed educational group session activities to be used under the project plan. This requirement applies regardless of whether the applicant plans to conduct the total program activities or plans to have part of them conducted through other organization(s) and whether program activities involve creating unique materials or using/distributing modified or intact materials already developed by others. Whenever feasible, CDC funded community-based organizations are encouraged to use a Program Review Panel established by a health department or an other CDC-funded organization rather than establish their own panel. The Surgeon General's Report on Acquired Immune Deficiency Syndrome (October 1986) and CDC-developed materials do not need to be reviewed by the panel unless such review is deemed appropriate by the recipient. Members of a Program Review Panel should:

(1) Understand how HIV is and is not transmitted; and
(2) Understand the epidemiology and extent of the HIV/AIDS problem in the local population and the specific audiences for which materials are intended.

b. The Program Review Panel will be guided by the CDC Basic Principles (in the previous section) in conducting such reviews. The panel is authorized to review materials only and is not empowered either to evaluate the proposal as a whole or to replace any other internal review panel or procedure of the recipient organization or local governmental jurisdiction.

c. Applicants for CDC assistance will be required to include in their applications the following:

(1) Identification of a panel of no less than five persons which represent a reasonable cross-section of the general population. Since Program Review Panels review materials for many intended audiences, no single intended audience shall predominate the composition of the Program Review Panel, except as provided in subsection (d) below. In addition:

(a) Panels which review materials intended for a specific audience should draw upon the expertise of individuals who can represent cultural sensitivities and language of the intended audience either through representation on the panels or as consultants to the panels.

(b) The composition of Program Review Panels, except for panels reviewing materials for school-based populations, must include an employee of a state or local health department with appropriate expertise in the area under consideration who is designated by the health department to represent the department on the panel. If such an employee is not available, an individual with appropriate expertise, designated by the health department to represent the agency in this matter, must serve as a member of the panel.

(c) Panels which review materials for use with school-based populations should include representatives of groups such as teachers, school administrators, parents, and students.

(d) Panels reviewing materials intended for racial and ethnic minority populations must comply with the terms of (a), (b), and (c), above. However, membership of the Program Review Panel may be drawn predominately from such racial and ethnic populations.

(2) A letter or memorandum from the proposed project director, countersigned by a responsible business official, which includes:

(a) Concurrence with this guidance and assurance that its provisions will be observed;

(b) The identity of proposed members of the Program Review Panel, including their names, occupations, and any organizational affiliations that were considered in their selection for the panel.

d. CDC-funded organizations that undertake program plans in other than school-based populations which are national, regional (multistate), or statewide in scope, or that plan to distribute materials as described above to other organizations on a national, regional, or statewide basis, must establish a single Program Review Panel to fulfill this requirement. Such national/regional/state panels must include as a member an employee of a state or local health department, or an appropriate designated representative of such department, consistent with the provisions of Section 2.c.(1).

   Materials reviewed by such a single (national, regional, or state) Program Review Panel do not need to be reviewed locally unless such review is deemed appropriate by the local organization planning to use or distribute the materials. Such national/regional/ state organization must adopt a national/ regional/statewide standard when applying Basic Principles 1.a. and 1.b.

e. When a cooperative agreement/grant is awarded, the recipient will:

   (1) Convene the Program Review Panel and present for its assessment copies of written materials, pictorials, and audiovisuals proposed to be used;

   (2) Provide for assessment by the Program Review Panel text, scripts, or detailed descriptions for written materials, pictorials, or audiovisuals which are under development;

   (3) Prior to expenditure of funds related to the ultimate program use of these materials, assure that its project files contain a statement(s) signed by the Program Review Panel specifying the vote for approval or disapproval for each proposed item submitted to the panel; and

   (4) Provide to CDC in regular progress reports signed statement(s) of the chairperson of the Program Review Panel specifying the vote for approval or disapproval for each proposed item that is subject to this guidance.

Materials Submission Form

District of Columbia HIV Prevention Community Planning Group, Materials Review Committee

Instructions:

1. Use one (1) form for each publication, curricula or other material you are submitting for review. Materials submitted without this form will **not** be reviewed.
2. Submit ten (10) copies of each item to:

For material for a **HAA**-funded program:

(*Name of Program Monitor*)
Materials Review Committee
HIV/AIDS Administration
717 14th Street NW, Suite 1000
Washington, DC 20005

For material for a program funded directly by **CDC**:

Ronnie Vanderhorst
Materials Review Committee
HIV/AIDS Administration
717 14th Street NW, Suite 1000
Washington, DC 20005

Title or Description of Material: _____

_____

This is the ☐ **First** Submission of this material ☐ **Second** Submission

Type of Material: ☐ Educational Brochure ☐ Program Brochure ☐ Flyer ☐ Palm Card ☐ Poster

☐ Radio ad or script ☐ TV ad or script ☐ Newspaper ad ☐ Curricula for workshops ☐ Training manual

☐ Survey Instrument ☐ Other (describe): _____

Language: ☐ English ☐ Spanish ☐ Chinese ☐ ASL ☐Other: _____

Target Audience (Check all that apply):

☐ Blacks ☐ Whites ☐ Latinos ☐ Asians & Pacific Islanders ☐ Other: _____

☐ General Population ☐ Youth (13-19) ☐ Young Adults (20-24) ☐ Other: _____

☐ Hetero. Men ☐ Hetero. Women ☐ Gay/Bi men ☐ MSM ☐ IDUs ☐ Women At-Risk ☐ Other: _____

Submitted by (organization): _____

Contact Person: _____

Contact Telephone No. _____ Fax No. _____ E-Mail _____

Submission Date: _____

- For items used in a program **funded by HAA**, what is the program's Grant Number? _____
- For items used in a program **funded directly by the CDC**, what is the RFA announcement number or Program #: _____

For CPG Use Only: CPG I.D. # _____

Project Officers' Materials Submission Form

PO's Name: _____

PO's Signature: _____

Date of Submission: _____ **Grantee:** _____

Grant #: _____ **Target Population/s:** _____

I have reviewed the attached material/s and determined that they meet the needs of the target population for this grant, as reflected in the program plan and the goals and objectives of the program.

(1) Title or Description of Material: _____

_____

Type of Material: ☐ Educational Brochure ☐ Program Brochure ☐ Flyer ☐ Palm Card ☐ Poster

☐ Radio ad or script ☐ TV ad or script ☐ Newspaper ad ☐ Curriculum for workshops

☐ Training manual ☐ Survey Instrument ☐ Other (describe): _____

Prevention Materials Approval/Disapproval Form **CPG I.D. # _____**

The Materials Review Committee of the HPCPG has reviewed the material described below and ☐ **Approved** it for use in HIV prevention activities funded by the CDC or HAA ☐ **Not** approved it for use in HIV prevention activities funded by the CDC or HAA	The vote by the committee was: _____ Votes For **Approval** _____ Votes For **Non-Approval**

Committee Chair Name (printed): _____

Committee Chair Signature: _____ Date: _____

Title or Description of Material: _____

Submitted by (organization): _____

Type of Material: ☐ Educational Brochure ☐ Program Brochure ☐ Flyer ☐ Palm Card ☐ Poster

☐ Radio ad or script ☐ TV ad or script ☐ Newspaper ad ☐ Curricula for workshops ☐ Training manual

☐ Survey Instrument ☐ Other (describe): _____

Language: ☐ English ☐ Spanish ☐ Chinese ☐ ASL ☐Other: _____

Target Audience (Check all that apply):

☐ Blacks ☐ Whites ☐ Latinos ☐ Asians and Pacific Islanders ☐ Other: _____

☐ General Population ☐ Youth (13-19) ☐ Young Adults (20-24) ☐ Other: _____

☐ Hetero. Male ☐ Hetero. Female ☐ Gay/Bi men ☐ MSM ☐ IDUs ☐ At-Risk. Female ☐ Other: _____

Criteria (Check the appropriate boxes to indicate whether the material met the criteria)	**Meets** Criteria	Does **NOT** Meet Criteria	Not Applicable
1. The material uses terms, descriptors or displays necessary for the intended audience to understand dangerous behaviors and explains less risky practices concerning HIV transmission			
2. The material does not promote or encourage, directly, homosexual or heterosexual sexual activity or intravenous substance abuse.			
3. The program provides accurate information about various means to reduce an individual's risk of exposure to, or the transmission of, HIV.			
4. The material is not obscene			
5. The program includes information about the harmful effects of promiscuous sexual activity and intravenous substance abuse, and the benefits of abstaining from such activities			
6. Educational sessions do not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices			

Comments: _____

D.C. DEPARTMENT OF HEALTH, HIV/AIDS ADMINISTRATION
PREVENTION AND INTERVENTION SERVICES DIVISION

Project Officers Materials Review Form

_____, Project Officer for _____
(name) (Agency name & Grant #)

reviewed the material described below for compliance with Section 2500 of the Public Health Service Act and

☐ **Approved** it for use in HIV prevention activities funded by the HAA or the CDC.

☐ **Not** approved it for use in HIV prevention activities funded by HAA or the CDC

Signed: Date:

Title or Description of Material: _____

Type of Material: ☐ Educational Brochure ☐ Program Brochure ☐ Flyer ☐ Palm Card ☐ Poster

☐ Radio ad or script ☐ TV ad or script ☐ Newspaper ad ☐ Curricula for workshops ☐ Training manual

☐ Survey Instrument ☐ Other (describe): _____

Language: ☐ English ☐ Spanish ☐ Chinese ☐ ASL ☐Other: _____

Target Audience (Check all that apply):

☐ Blacks ☐ Whites ☐ Latinos ☐ Asians and Pacific Islanders ☐ Other: _____

☐ General Population ☐ Youth (13-19) ☐ Young Adults (20-24) ☐ Other: _____

☐ Hetero. Male ☐ Hetero. Female ☐ Gay/Bi men ☐ MSM ☐ IDUs ☐ At-Risk. Female ☐ Other: _____

Criteria (Check the appropriate boxes to indicate whether the material met the criteria)	**Meets** Criteria	Does **NOT** Meet Criteria	Not Applicable
1. The material uses terms, descriptors or displays necessary for the intended audience to understand dangerous behaviors and explains less risky practices concerning HIV transmission			
2. The material does not promote or encourage, directly, homosexual or heterosexual sexual activity or intravenous substance abuse.			
3. The program provides accurate information about various means to reduce an individual's risk of exposure to, or the transmission of, HIV.			
4. The material is not obscene			
5. The program includes information about the harmful effects of promiscuous sexual activity and intravenous substance abuse, and the benefits of abstaining from such activities			
6. Educational sessions do not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices			